

FILED DEC 27 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42039
Registrar's No. 10560

#115934

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo.	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2069	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If rural, give location) 1606a Hodiament Ave	
3. NAME OF DECEASED (Type or Print) a. (First) ADA b. (Middle) BRIGGS c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) December 11th, 1950	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Jan. 12 1889
9. AGE (In years last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
11. BIRTHPLACE (State or foreign country) Britt Iowa		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Stephan Hill		13b. MOTHER'S MAIDEN NAME Carrie Walton	
14. NAME OF HUSBAND OR WIFE Frank Briggs		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Arthur Briggs; 1606a Hodiament Ave	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peritonitis due to perforating colon ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of rectum & generalized abdominal metastasis DUE TO (c) Perforation of colon due to Carcinoma II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 1574X		22. I hereby certify that I attended the deceased from 10/18/50 to 12/11/50, that I last saw the deceased alive on 12/11/50, 19, and that death occurred at 7:35am m., from the causes and on the date stated above.	
23a. SIGNATURE Jean C. Gladden M.D.		23b. ADDRESS 1515 Lafayette Ave.,	
23c. DATE SIGNED 12/11/50		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 12/12/50		24c. NAME OF CEMETERY OR CREMATORY Iowa Falls Iowa	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE Drehmann-Harral; 1905 Union Blvd.	
DATE REC'D BY LOCAL REG. DEC 11 1950		REGISTRAR'S SIGNATURE J. B. Luster	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

mt

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by_____

working under my personal supervision.

Student Embalmer No.....

Signed.....

Warren A. Carver

Signed.....
Student Embalmer

Licensed Embalmer No. *353x*

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.